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9
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11
12 **UNITED STATES DISTRICT COURT**
13 **EASTERN DISTRICT OF WASHINGTON**

14 ERIC WRIGHT, INDIVIDUALLY
15 AND IN HIS CAPACITY AS
16 PERSONAL REPRESENTATIVE
17 OF THE ESTATE OF STEVEN O.
18 WRIGHT; AND, AMY SHARP,
19 INDIVIDUALLY,

20 Plaintiffs,

21 v.

22 THE UNITED STATES OF
23 AMERICA; MEDFORD
24 CASHION, M.D.; STAFF CARE,
25 INC.,

26 Defendants.

No. 2:15-cv-00305-TOR

DECLARATION OF
BRUCE WAPEN, M.D. IN
OPPOSITION TO UNITED
STATES' MOTION FOR
SUMMARY JUDGMENT

1 BRUCE WAPEN, M.D. swears under penalty of perjury as follows:

2 1. I am over the age of 18 years and competent to testify to the matters
3 stated herein, and I make this Declaration based on personal knowledge.
4

5 2. I have practiced emergency medicine for 37-years (1976 through
6 2013) and have been board certified in emergency medicine for 30-years (1984
7 through 2014). I am licensed to practice medicine in the States of California &
8 Washington. I am familiar with the standard of care for emergency physicians
9 and have qualified as an expert witness in emergency medicine at trials in the
10 States of California, Alaska, Idaho, Michigan, Arizona, New Mexico and
11 Nevada. The opinions expressed in this report are based on knowledge obtained
12 through my education, training and experience as well as from research specific
13 to this case.
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17 3. I have been retained by counsel for Plaintiff to render opinions
18 regarding the medical management of Steven O. Wright in the Emergency
19 Department (ED) at the Veteran Affairs Medical Center in Spokane, WA on 2
20 August 2014. At the time of this event, I had been retired from the active practice
21 of emergency medicine for 8-months; but I was still board certified in emergency
22 medicine.
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1 4. In preparing this Declaration, I have reviewed the following
2 documents:

3 -Veteran Affairs Medical Center ED records 8-2-14, visits # 1 & #2

4 -Certificate of Death 8-11-14

5 -Autopsy Report 8-12-14

6 -Institutional Disclosure of Adverse Event 8-12-14

7 -Plaintiff's Initial Discovery 2-26-16

8 -Depositions of: Medford Cashion, MD; Shea McManus, MD; Karla
9 Linton, LPN; Robert Ready, RN; Jill Palmer, RN; Kimberly Morris, MD;
10 Elizabeth Whitley Ford, RN; and Matthew Haugen, RN

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14 5. In preparing this report, I have researched information from the
15 following sources:

16 -ACEP Clinical Policy: Neuroimaging and Decision Making in Adult Mild
17 Traumatic Brain Injury in the Acute Setting, *Annals of Emergency*
18 *Medicine*, Volume 52, No. 6: pages 714-727, December 2008.

19 -David W. Wright & Lisa H. Merk, "*Head Trauma in Adults and*
20 *Children*," Tintinalli's Emergency Medicine: A comprehensive Study
Guide - 7th Edition, pages 1692-1709, 2011.

21 -Karni A, Holtzman R, Bass T, et al: Traumatic head injury in the
22 anticoagulated elderly patient: a lethal combination, *Am Surg* 67(11): 1098,
2001.

23 -Mina AA, Knipfer JF, Park DY, et al: Intracranial complication of
24 preinjury anticoagulation in trauma patients with head injury, *J Trauma*
25 53(4): 668, 2002.

26 -Cohen DB, Rinker C, Wilberger JE: Traumatic brain injury in
anticoagulated patients, *J Trauma* 60(3), 553, 2006.

1 -Mack L, Chan S, Silva J, et al: The use of head computed tomography in
2 elderly patients sustaining minor head trauma, *J Emerg Med* 24:157-162,
2003.

3 -Ohm C, Mina A, Howells G, et al: Effects of antiplatelet agents on
4 outcomes for elderly patients with traumatic intracranial hemorrhage. *J*
5 *Trauma* 58: 518-522, 2005.

6 **I. Factual Summary of Events**

7 6. Steven O. Wright ("SW"), a 70-year-old male, presented to the
8
9 Spokane, WA Veteran Affairs Medical Center ED accompanied by a friend at
10 about 11:00am on 8-2-14. SW complained of a left knee injury secondary to a
11 fall down two steps on 7-27-14. He had been using crutches to help him walk but
12 complained of pain, swelling and bruising in this left leg. He was evaluated by
13 Dr. Shea McManus. The left leg displayed swelling and purplish discoloration
14 from the distal thigh to the foot with "severe anasarca/edema," but no such
15 swelling of the right leg or scrotum was noted. (Anasarca: generalized massive
16 edema [Dorland's Illustrated Medical Dictionary - 30th Edition])
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19 7. It was documented that SW was taking the anticoagulant warfarin
20 (Coumadin) for treatment of chronic atrial fibrillation (A-fib) as well as a baby
21 aspirin a day (both are blood-thinners, but aspirin is classified as an antiplatelet
22 agent, not an anticoagulant). An INR was ordered to measure his anticoagulation
23 status. His INR was elevated at 1.5, which is compatible with taking warfarin;
24
25 but that level is not in the fully therapeutic range for the treatment of A-fib. An
26

1 EKG showed A-fib but was negative for acute findings. Tibia/fibula x-rays of the
2 left leg were obtained which did not show evidence of an acute fracture but were
3 read as showing "Diffuse [left] lower extremity edema ..." A chest x-ray showed
4 mild prominence of the central vasculature *without* overt changes of pulmonary
5 edema. At 1:00pm, SW was given Lasix 80mg orally for his edema, and he put
6 out 700ml of urine by 3:30pm. At 3:35pm, SW was given warfarin 5mg orally
7 plus a second anticoagulant, enoxaparin (low-molecular weight heparin –
8 tradename Lovenox), which was given as a 100mg subcutaneous injection.
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12 8. A Doppler ultrasound (U/S) of the left leg to rule-out deep vein
13 thrombosis (DVT) could not be done at the VA Medical Center, and SW was sent
14 to Holy Family Hospital (HFH) by ambulance to have that test done at 5:40pm.
15 The injection of enoxaparin, noted above, was given as prophylaxis for possible
16 DVT pending the results of the U/S. At 6:03pm, Dr. McManus went off-shift and
17 turned the care of SW over to Dr. Medford Cashion. In his deposition, Dr.
18 McManus stated that he had intended to admit SW to the hospital regardless of
19 the U/S findings; and he communicated that intent to Dr. Cashion. (McManus
20 Depo 43:20 – 44:21)
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24 9. SW returned to the VA Medical Center at 6:45pm, and the records
25 do not indicate that a DVT was found. Dr. Cashion's diagnostic impression was:
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1 "Strain and contusion left knee." Dr. Cashion noted that SW had crutches with
2 him and had a knee immobilizer at home. In the ED, SW was able to walk using
3 only one crutch. SW was discharged from the ED with instructions to use his
4 crutches and knee immobilizer, and he was given a referral to follow-up in the
5 orthopedic clinic. He left the ED at approximately 8:05pm. (VAMC pg. 41).
6
7

8 10. After leaving the ED but while still in the hospital parking lot, SW
9 had an unwitnessed fall. Matthew Haugen, RN was just leaving the hospital after
10 having finished his day shift. He did not see SW fall but noticed him standing by
11 a wheelchair rack some distance from the hospital doors. Nurse Haugen
12 remembered that SW "was just standing there," "seemed unclear about his
13 situation," and "implied that he was driving [that is, that he would be driving
14 himself home from the parking lot]." (Haugen Depo 11:16 – 12:20) Nurse
15 Haugen felt that SW was "alert" and did not feel that he appeared "dazed"
16 (Haugen Depo 12:25 – 13:4); instead, he described SW as being "stalled."
17 (Haugen Depo 25:5-14) Nurse Haugen put SW in a wheelchair, wheeled him
18 back into the ED, and presented him to the triage nurse to be cared for.
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23 11. Elizabeth Whitley-Ford, RN was the triage and charge nurse that
24 evening. She did not document and does not remember her conversation with
25 Nurse Haugen. (Whitley-Ford Depo 22:4-15) Her "Chief Complaint" triage note
26

1 was time-stamped 8:50pm on 8-2-14. It stated: "Pt dc'd home, was walking out to
2 POV with ride home on crutches, lost footing and fell forward into bike rack
3 [sic], going between bars and hitting head on ground. Lacerations, skin abrasions
4 to rt [sic] forehead, bump to rt [sic] forehead. No LOC, minimal bleeding to
5 forehead. Pt alert and oriented, denis [sic] pain, just scrape to head, requesting to
6 go home now."
7

8
9 12. Nurse Whitley-Ford's physical assessment documented that SW was
10 "alert and oriented X 3," that his eyes showed "PERRL," and that the forehead
11 displayed "abrasion tort [sic] forehead, bump tort [sic] forehead." That note was
12 entered into and/or signed in the computerized patient record system (CPRS) at
13 11:18pm.
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16 13. SW was seen, again, by Dr. Cashion who documented this history
17 at 8:43pm: "70m c/o head injury. He was discharged from this ER, and was using
18 his crutches, when he fell into the bike rack [sic] out in our parking lot having
19 tripped. A witness says his head went through the bike rack. Pt states his head hit
20 the pavement but he wasn't knocked out. He has no headache and no neck or
21 back pain, in fact no new pain." Dr. Cashion did not mention the presence or
22 absence of an alteration in mental state (i.e. feeling dazed, disoriented or
23 confused), amnesia, or other signs of concussion while SW was still in the
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1 parking lot immediately following the blow to the head. The physical
 2 examination in the ED revealed a "3x4 cm fresh abrasion, mild swelling left
 3 upper forehead," and the neurologic exam was normal with "Mental status
 4 normal for age; PERRL, moving all 4 extr well." Interestingly, the extremities
 5 were now documented as showing "no sign injury."
 6

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 8 14. Dr. Cashion's diagnostic impression was "Head injury, without
 9 concussion, contusion forehead, on warfarin" (Spokane VAMC pg. 16)¹, and his
 10 "Assessment & Plan" were "Abrasion and contusion forehead, without
 11 concussion, on warfarin, today's INR 1.5. Pt and friend comfortable with home
 12 observation. Instruction sheet. Followup urgent care Aug 4." (Spokane VAMC
 13 pg. 25) That instruction sheet, however, is not in evidence as part of the medical
 14 records; and Nurse Whitley-Ford cannot recall talking to SW about the risks of
 15 bleeding into his head. (Whitley-Ford Depo 74:18 – 75:24) SW was given a
 16 tetanus booster on re-admission to the ED at 8:50pm; and he was discharged
 17 from the ED sometime around 11:00pm, although the precise time of discharge
 18 was not recorded.
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 22 15. SW was found lifeless in his bathtub on the morning of 8-3-14. An
 23 autopsy was performed by Jeffrey M. Reynolds, MD on 8-7-14. He found:
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 26 ¹ Excerpts from the medical records referenced in this Declaration are attached as Exhibit "A" to the
 Declaration of Richard C. Eymann.

1 "Superficial abrasion is present on the left frontal scalp, measuring 2 x 4 cm.
 2 Only mild swelling present in this area ... No damage to the scalp is visible or
 3 palpable." (Autopsy Report pg. 2) "No other evidence of head trauma is present."
 4 (Autopsy Report pg. 4) However, once the skull was opened, Dr. Reynolds found
 5 that "...a large (198 cc) subdural hematoma is present on the right with an
 6 obvious left shift of the brain and pressure phenomena affecting the right
 7 frontoparietal region." His final pathologic diagnoses included "Large, acute right
 8 frontoparietal subdural hematoma," and the Cause of Death was listed as "Acute
 9 subdural hematoma secondary to fall and anticoagulation." A Certificate of Death
 10 was completed by the coroner, Peter J. Martin, on 8-11-14 and reflected the
 11 findings noted at autopsy with the exception that the Certificate of Death listed
 12 the time of death as 12: 30am on 8-3-14, and the Autopsy Report listed the time
 13 of death as 9:30am on 8-3-14.

18 II. Standard of Care

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 20 16. One of the issues in this case is the degree of head and/or brain
 21 injury that SW suffered. The American College of Emergency Physicians
 22 (ACEP) 2008 Clinical Policy: Neuroimaging and Decision Making in Adult Mild
 23 Traumatic Brain Injury [TBI] in the Acute Setting makes this enlightening
 24 comment (see referenced article, page 715): "Terms used have included
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1 "concussion," mild "TBI," "class I TBI," and "low-risk TBI." Even terms "head"
2 and "brain" have been used interchangeably. Head injury and TBI are 2 distinct
3 entities that are often, but not necessarily, related. A head injury is best defined as
4 an injury that is clinically evident on physical examination and is recognized by
5 the presence of ecchymosis, lacerations, deformities, or cerebrospinal fluid
6 leakage. A traumatic brain injury refers specifically to an injury to the brain itself
7 and is not always clinically evident; if unrecognized, it may result in an adverse
8 outcome."
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12 17. The commonly used term "concussion" (synonymous with mild
13 TBI) is best described as an alteration in mental state (i.e. feeling dazed,
14 disoriented or confused up to and including a transient loss of consciousness)
15 associated with trauma to the head with or without amnesia of the traumatic event
16 and events immediately preceding and/or following the injury. One does not have
17 to lose consciousness to qualify as having suffered a concussion type TBI.
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20 18. It is clear from Nurse Whitley-Ford's and Dr. Cashion's notes that
21 SW had head trauma that resulted in visible, external injuries to his forehead. The
22 question as to whether or not he had brain injury should have been assessed via:
23 1) a probing History of the Present Illness (HPI), 2) a thorough neurologic
24 Physical Examination (PE), and 3) brain imaging if indicated.
25
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1 19. The HPI should have included SW's answers to questions such as:
2 Did you feel dazed, disoriented or confused after hitting your head? Did you see
3 stars or lights? Do you remember what made you fall [immediate pre-event
4 memory vs. amnesia]? Do you remember hitting your head [memory of vs.
5 amnesia for the event]? Do you remember how you got up from the fall
6 [immediate post-event memory vs. amnesia]? The chart documents that SW was
7 alert and oriented at the time of his re-admission to the ED, but it does not appear
8 that either Nurse Whitley-Ford or Dr. Cashion asked the questions noted above
9 other than Nurse Whitley-Ford's reporting that SW "lost footing" and Dr.
10 Cashion's note regarding SW's "having tripped." No one charted Nurse Haugen's
11 impressions that SW was just standing there as though he were stalled, that he
12 seemed unclear about his situation, or that he seemed confused about who was to
13 drive him home. Without asking all of the questions noted above and assessing
14 the answers, no medical provider could know whether this visible, external
15 forehead injury caused a concussion/mild TBI or not. Failing to ask those
16 questions and record the answers was below the standard of care in emergency
17 medicine.

18 20. The neurologic examinations that were performed by Nurse
19 Whitley-Ford and Dr. Cashion were adequate with Nurse Whitley-Ford's exam

1 (the better of the two) documenting that SW could move against gravity and had
2 normal grips and ability to push his feet [against resistance?] in addition to his
3 being A&O x 3 with PERRLA. What is conspicuously missing from each of their
4 PEs is a Glasgow Coma Scale (GCS) score. However, from the exams that are
5 documented regarding SW's mental status once he was back in the ED, it is likely
6 that his score was normal at 15.
7

9 21. That leaves us with the third component of assessment - imaging.
10 Mild TBIs associated with findings such as a GCS of 15, no focal neurologic
11 deficit, and no protracted vomiting do not usually require imaging *unless* the
12 patient is over 60-years-of-age or has a coagulopathy (alteration of normal
13 clotting as in someone who is taking warfarin, aspirin, and has recently been
14 injected with enoxaparin). Under those circumstances, as noted on page 718 of
15 the 2008 ACEP Clinical Policy: Neuroimaging and Decision Making in Adult
16 Mild Traumatic Brain Injury in the Acute Setting, a noncontrast head CT is
17 indicated as a Level A recommendation (Level A recommendations are
18 "Generally accepted principles for patient management that reflect a high degree
19 of clinical certainty (ie, based on strength of evidence Class I or overwhelming
20 evidence from strength of evidence Class II studies that directly address all of the
21 issues." - ACEP Policy page 717).
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1 22. This mandate is reinforced by the findings of a 2003 study published
2 in *The Journal of Emergency Medicine* (see reference above) that clinical
3 findings (signs and symptoms) *cannot* reliably identify those patients with an
4 intracranial injury (ICI) secondary to minor head trauma (MHT). That study
5 noted: "Only 1 of 13 signs and symptoms correlated with ICI. In this study, no
6 useful clinical predictors of intracranial injury in elderly patients with MHT were
7 found. Current protocols based on clinical findings may miss 30% of elderly ICI
8 patients. Head CT scan is recommended on all elderly patients with MHT."
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12 23. Treatment with enoxaparin, an anticoagulant, is a risk factor for
13 intracranial hemorrhage with minor head trauma in addition to the risks from
14 being anticoagulated with warfarin and having platelet function inhibited by
15 aspirin. From a 2002 study published in *The Journal of Trauma* (see reference
16 above): "These data indicate that the trauma patient with preinjury
17 anticoagulation such as warfarin or even aspirin who has an intracranial injury
18 has a four-to-fivefold higher risk of death than the nonanticoagulated patient."
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21 24. Clearly, then, a CT scan of the head/brain was required in this
22 patient, and Nurse Whitley-Ford noted SW should have had a CT scan of his
23 head that night. (Whitley-Ford Depo 53:18 – 56:5) It is my opinion that a head
24 CT would have shown evidence of an intracranial hemorrhage in progress.
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1 Failure to order a head CT was below the standard of care in emergency
2 medicine.

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4 25. As already noted, Dr. Shea McManus thought that SW was ill
5 enough that he ought to be admitted to the hospital even if the Doppler
6 ultrasound of the leg were negative for DVT, which it was. Now, add to SW's
7 baseline infirmities a fall that results in head trauma when he is already
8 anticoagulated with two potent, pharmacologic agents plus aspirin. As noted
9 above, it is my opinion that a head CT would have shown evidence of an early
10 intracranial hemorrhage, which would have mandated neurosurgical consultation
11 and admission/transfer. However, even if a CT scan done immediately after the
12 head injury were not yet positive for the intracranial hemorrhage that killed him,
13 SW still should have been admitted for observation.
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17 26. As noted in the 2001 presentation to the *Annual Meeting of the*
18 *Southeastern Surgical Congress* (see reference above): "In our experience
19 treating the elderly anticoagulated trauma patient we have developed several
20 practical guidelines to facilitate the acute care of these patients. All patients over
21 age 65 who are on oral anticoagulation therapy are admitted and undergo head
22 CT scanning even after an apparently minor head injury." And, in her deposition,
23 Nurse Whitley-Ford said that she thought SW should have been admitted for
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1 overnight observation. (Whitney-Ford Depo 62:24) Dr. Cashion's failure to
2 arrange for SW to be admitted to the hospital was below the standard of care in
3 emergency medicine.
4

5 **III. Causation**

6 27. Per the Autopsy Report, SW's cause of death was "Acute subdural
7 hematoma secondary to fall and anticoagulation." It is more probable than not
8 that a head CT done at the time of the second ED visit would have shown an
9 intracranial hemorrhage in progress. The causation question arises, then, "Could
10 treatment have been rendered that would have prevented this awake and oriented
11 individual from going on to die from his intracranial hemorrhage?" The answers
12 involve dealing with the anticoagulation effects of warfarin and enoxaparin
13 (aspirin's effect cannot be reversed) and employing neurosurgical intervention,
14 should that treatment modality become indicated.
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18 28. There are many different, life-threatening, bleeding emergencies
19 exacerbated by the presence of anticoagulants; and those patients are routinely
20 saved from exsanguination by the reversal of the effects of the blood-thinning
21 agents. Warfarin can be reversed with a combination of vitamin K and either
22 fresh frozen plasma (FFP) or prothrombin complex concentrate (PCC).
23 Compared to warfarin, enoxaparin has a relatively short half-life of only 4.5-
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1 hours. If it needs to be reversed immediately, that can be partially accomplished
2 with protamine sulfate; but even if nothing is done to reverse enoxaparin, it's
3 effect rapidly wears off. Reversing the effects of warfarin and enoxaparin would
4 have decreased SW's tendency to continue bleeding.
5

6 29. As previously noted, SW's acute subdural hematoma (brain bleed)
7 should have been imaged with CT scanning, and SW should have been admitted
8 to the hospital to the service of a neurosurgeon or transferred to another hospital
9 that had neurosurgical capability. In my experience, neurosurgical management
10 of an acute subdural hematoma is usually successful in saving the patient's life
11 and preserving brain function. If bleeding stops before neurologic symptoms
12 develop, no surgical intervention is required. If the hematoma becomes large
13 enough to cause neurologic symptoms, the hematoma can be drained via a burr-
14 hole in the skull. If that is not feasible or effective, the bleeding can be addressed
15 in the operating room via a formal craniotomy.
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20 30. It is more probable than not that reversing the anticoagulation effects
21 of warfarin and enoxaparin along with appropriate neurosurgical intervention as
22 needed would have prevented SW's death from his intracranial hemorrhage.
23 Failure to elicit an appropriate HPI and perform a head CT caused Dr. Cashion to
24 miss the brain bleed. Failure to admit SW to the hospital, even in the absence of
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1 positive CT findings, obviated the chance to employ medical observation as a
2 means of spotting SW's deterioration while there was still time to remediate it.
3
4 Dr. Cashion's failures to meet the standard of care at all of these levels caused or
5 significantly contributed to SW's death from brain hemorrhage.

6
7 **IV. Standard of Care Opinion**

8 31. Based on a reasonable degree of medical certainty and on a more
9 probable than not basis, my opinion is that Dr. Medford Cashion fell below the
10 standard of care in emergency medicine for the following reasons:
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- 12 a. Failure to take an adequate History of the Present Illness;
13 b. Failure to order a head CT;
14 c. Failure to diagnose the intracranial hemorrhage; and
15 d. Failure to arrange for Mr. Wright to be admitted to the hospital.
16

17
18 **V. Causation Opinion**

19 32. Based on a reasonable degree of medical certainty and on a more
20 probable than not basis, my opinion is that Dr. Medford Cashion's failures to
21 meet the standard of care in emergency medicine, as described and itemized
22 above, caused Mr. Wright to be sent home from the ED with an unrecognized
23 intracranial hemorrhage in progress, which caused his death.
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1 I declare under penalty of perjury under the laws of the United States that
2 the foregoing is true and correct.

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4 DATED this 3rd day of May, 2017, at Foster City, California.

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7 _____
8 Bruce Wapen, MD, FACEP
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CERTIFICATE OF SERVICE

I hereby certify that on 5/8/17, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which will send notification of such filing to the following participants:

Rudy J. Verschoor Rudy.J.Verschoor@usdoj.gov

Joseph Derrig Joseph.Derrig@usdoj.gov

Amanda K. Thorsvig Amanda@favros.com

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s/Richard C. Eymann
RICHARD C. EYMANN